STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155666	A. BUILDING _____ B. WING _____	C 12/31/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESLEY HEALTHCARE AND REHABILITATION CENTER	**1751 WESLEY ROAD AUBURN, IN 46706**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS This visit was for the Investigation of Complaint IN00141556. Complaint IN00141556 - Substantiated. No deficiencies related to the allegation are cited. This visit was in conjunction with a Post Survey Revisit (PSR) to the Investigation of Complaint IN00140729 completed on December 11, 2013. Survey dates: December 30 & 31, 2013 Facility number: 000307 Provider number: 155666 AIM number: 100285660 Survey team: Rick Blain, RN - TC Carol Miller, RN Census bed type: SNF/NF: 48 Total: 48 Census payor type: Medicare: 2 Medicaid: 42 Other: 4 Total: 48 Sample: 3 Wesley Healthcare and Rehabilitation Center was found to be in compliance with 42 CFR Part 483, Subpart B and 410 IAC 16.2 in regard to the Investigation of Complaint IN00141556.	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 000	Continued From page 1 Quality review completed on January 2, 2014 by Randy Fry RN.	F 000		